

**Addressing Mental Health Stigma in Hispanic Adolescents**

By

Joanna Marroquin

A Master's Paper submitted to the faculty of  
the University of North Carolina at Chapel Hill  
in partial fulfillment of the requirements for  
the degree of Master of Public Health in  
the Public Health Leadership Program

Chapel Hill

Spring 2018

---

***Dr. Rohit Ramaswamy***

---

***Date***

---

*Karin Yeatts*

***Dr. Karin Yeatts***

*4/24/18*

---

***Date***

© 2018  
Joanna M Marroquin  
ALL RIGHTS RESERVED

## **ABSTRACT**

Joanna Marroquin: Addressing Mental Health Stigma in Hispanic Adolescents  
(Under the direction of Rohit Ramaswamy)

High mental health stigma in Hispanic is an area of study that requires more attention. There are significant gaps in research on this subject. This is especially true among Hispanic adolescents who are still developing and are in an influential part of their life. Hispanic adolescents have higher rates of considering suicide, making suicide plans, and actually attempting suicide than white adolescents. There are several reasons why individuals might not seek treatment from a provider. A serious reason is that many experience high mental health stigma. Fearing or experiencing negative labels associated with having a mental illness can lead to individuals refusing to seek treatment.<sup>1</sup> Latinos are also less likely seek mental health services compared to other ethnicities or races. Interventions that can help lessen mental health stigma in adolescents may help in increasing treatment rates. The pilot program proposed is based on the SPEAK program by Bulanda et al. (2014). With the aid of the Interactive Systems Framework for Dissemination and Implementation, this program will be adapted to Hispanic adolescents. The primary goal of this program is to reduce mental health stigma.

## **Acknowledgements**

I would like to thank Dr. Rohit Ramaswamy for being a mentor and guiding me through this process and Dr. Karin Yeatts for keeping me motivated to pursue addressing mental health stigma in Hispanics. I would also like to thank my partner Michael Sessum for supporting me through this long process and my family for getting me here. I would also like to thank everyone above and those not mentioned from The University of North Carolina Chapel Hill for aiding me through my own mental illness.

## Table of Contents

<b><u>ADDRESSING MENTAL HEALTH STIGMA IN HISPANIC ADOLESCENTS .....</u></b>	<b><u>1</u></b>
<b><u>INTRODUCTION: OVERVIEW OF MENTAL HEALTH IN THE POPULATION .....</u></b>	<b><u>1</u></b>
<b><u>INTERVENTIONS TO REDUCE STIGMA IN ADOLESCENTS.....</u></b>	<b><u>8</u></b>
<b><u>KEY CONSIDERATIONS FOR DEVELOPING A STIGMA REDUCTION PROGRAM FOR HISPANIC ADOLESCENTS .....</u></b>	<b><u>14</u></b>
<b><u>IMPLEMENTING A STIGMA REDUCTION INTERVENTION TARGETED AT HISPANIC ADOLESCENTS .....</u></b>	<b><u>16</u></b>
<b><u>A MODEL FOR PROGRAM IMPLEMENTATION: THE INTERACTIVE SYSTEMS FRAMEWORK.....</u></b>	<b><u>22</u></b>
<b><u>ROLES OF LEADERS IN REDUCING MENTAL HEALTH STIGMA AMONG HISPANIC ADOLESCENTS .....</u></b>	<b><u>28</u></b>
<b><u>CONCLUSION .....</u></b>	<b><u>29</u></b>
<b><u>APPENDIX 1 .....</u></b>	<b><u>31</u></b>
<b><u>RESOURCES .....</u></b>	<b><u>34</u></b>

## **List of Tables**

Table 1 Youth Risk Surveillance Summary <sup>29</sup> .....	7
Table 2 Summary of Interventions .....	13
Table 3 Monitoring and Evaluation Plan.....	26

## List of Abbreviations

FPL	Federal Poverty Level
ISF	Interactive Systems Framework
NAMI	National Alliance of Mental Illness
NIH	National Institute of Health
PTSD	Post-Traumatic Stress Disorder
SAHMSA	Substance Abuse and Mental Health Services Administration
SPEAK	Share, Peace, Equality, Awareness, and Knowledge

## **Introduction: Overview of Mental Health in the Population**

### **Description of the global burden of mental health**

In the United States alone, approximately 43.8 million people, or 18 percent of the population, experiences mental illness in a given year.<sup>2</sup> Approximately 9.8 million are diagnosed with a serious mental illness that impairs their functioning.<sup>2</sup> In adults, approximately 1.1 percent are diagnosed with schizophrenia, 2.6 percent with bipolar disorder, 6.9 percent with major depression, and 18.1 percent experience an anxiety disorder such as post-traumatic stress disorder (PTSD).<sup>2</sup>

The burden of cost on the United States for not treating or poorly treating individuals with mental illness is significant. It is reported that the U.S. lost \$193.2 billion in potential earnings through the direct and indirect impact associated with mental illness, such as reduced labor supply, reduced educational attainment, incarceration, homelessness, medical complications, high rates of emergency room care, a high prevalence of pulmonary disease and early mortality.<sup>2</sup> Mood disorders are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44. Mortality rates also show that adults with serious mental illness die on average 25 years earlier than those without a mental illness, usually to medical conditions that are treatable.<sup>2</sup>

### **Outcomes for Vulnerable Populations**

Vulnerable populations include the poor, the homeless, the incarcerated and minorities, all of whom have a higher risk of mental illness. People in lower socioeconomic status have been found to have a higher risk for mental illness.<sup>3</sup> Mental illness can compound the vulnerability



that already exists for economically disadvantaged populations.<sup>4</sup> Poverty is associated with anxiety, depression, and chronic exposure to stress.

Mental illness is also very prevalent among the homeless population. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 20 to 25 percent of the homeless population has a severe mental illness compared to only 6 percent of the general population.<sup>5</sup> It is estimated that over 26 percent of homeless adults living in shelters can be diagnosed with a severe mental illness and 46 percent have a severe mental illness and substance use disorder.<sup>2</sup>

The incarcerated population is another vulnerable section of the population.<sup>6</sup> In 2014, an estimated 20 percent of the prison population and 10 percent of the jail population could be diagnosed with a severe mental illness and these numbers are believed to have increased since then.<sup>6</sup> Not only are individuals with mental illness overrepresented in the criminal justice system, they also spend more time in jail than other inmates.<sup>7</sup>

Finally, people of color have less access to mental health services than do whites and are less likely to receive needed care. Also, when they are treated they are more likely to receive poorer quality of care.<sup>8</sup> From 2008 to 2012, White adults were far more likely to use mental health services in the past year with 16.6 percent of White adults utilizing services compared to only 8.6 percent of Black adults and 7.3 percent of Hispanic adults. White adults were also shown to utilize outpatient services, prescription psychiatric medications more frequently than Hispanic and Black adults.<sup>9</sup> Mental illness is associated with poorer self-care and overutilization of the emergency room, particularly among racial/ethnic minorities.<sup>10</sup> Children are the age group most impacted by poverty with Black and Hispanic children being disproportionately affected.<sup>11</sup>

The cost of services and lack of insurance coverage is one of the most common reasons for not utilizing mental health services among the poor and minorities.<sup>9</sup> According to the 2016 National Healthcare Quality and Disparities Report, people at or below 100 percent of the Federal Poverty Level (FPL) experienced worse access to care when compared to high-income people. Black and Hispanic populations have been shown to have worse access to care when compared with White population groups.<sup>12</sup> The percentage of uninsured poor adults was 26.7 percent of poor adults compared with 7.8 percent of adults who were not poor.<sup>12</sup> At the end of 2016, the percentage of people ages 18-64 who were uninsured was 8.9 percent of Whites, 14.6 percent of Blacks, and 25.9 percent of Hispanics.<sup>12</sup> While more people are getting care for mental illness, the percentage of those with a serious mental illness who are getting care has actually declined from 50 percent in 2000 to 44.6 percent in 2006.<sup>13</sup> Seniors with serious mental illness saw a more significant decline with 30.4 percent utilizing treatment in 2000 and only 20 percent in 2006.<sup>13</sup>

### **Mental illness in the adolescent population**

Adolescence is defined as the period of change between childhood and adulthood and is commonly referred to being between the ages of 13 and 19. However, this is partly a social construct because the concepts of childhood and adulthood often differ from one society to another. For example, in some societies, children are believed to have reached adulthood when they reach physical maturity.<sup>14</sup> In the United States, adolescence is defined by age and also takes into account societal norms such as supporting one's self and gaining independence from a parental figure. The defining characteristics of adolescence are the onset of puberty and the physical and psychological changes that occur during this stage. This makes it difficult to generalize adolescence across populations because these events can start earlier and end later

depending on the individual.<sup>15</sup> The United States Department of Health and Human Services Office of Adolescent Health currently defines adolescence to be between the ages of 10 and 19.

<sup>16</sup> The age range used for adolescents varies across different research studies. The minimal age used to describe adolescence was 10 and the maximum was 24. As a result, I will define adolescence to be between the ages of 10 and 24 and will be marked by the onset of puberty and include the various physical and psychological changes that occur up until the age of 24.

Adolescence is an important stage because this is the period of development when individuals begin learning the skills that will allow them to function as an adult. Multiple changes occur during this stage such as physical, intellectual, personality, social, and emotional developmental changes<sup>17</sup>. Increased cognitive and intellectual capacity makes stronger reasoning skills, logical and moral thinking, abstract thinking and rational judgments possible.

Adolescence is also an important developmental stage because changes taking place in the environment both affect and are affected by the internal changes of adolescence.<sup>18</sup> Many of the health issues that arise during adolescence also have implications on future health and development. The average onset of serious mental illnesses, such as schizophrenia, also coincides with this period of change. According to the World Health Organization, half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s.<sup>19</sup> According to the National Institute of Mental Health (NIMH), an estimated 49.5 percent of adolescents age 13-18 could be diagnosed with a mental disorder and of those, an estimated 22.2 percent had a severe impairment.<sup>20</sup>

If untreated, mental illness has been shown to severely impact the wider health and development of adolescents as well as their potential to live fulfilling and productive lives.<sup>21</sup> Mental illness in adolescence is associated with several health and social outcomes such as

higher alcohol, tobacco, and illicit substances use, adolescent pregnancy, poor academic achievement and increased school drop-out rates, delinquent behaviors, suicide, substance use, as well as increased risk of mental illness later adulthood.<sup>20</sup> Over one-third (37%) of students with a mental health condition age 14–21 and older who are served by special education drop out—the highest dropout rate of any disability group.<sup>2</sup> Suicide is the 10th leading cause of death in the U.S.,<sup>20</sup> the 3rd leading cause of death for people aged 10–14 and the 2nd leading cause of death for people aged 15–24.<sup>2</sup> More than 90% of children who die by suicide have a mental health condition.<sup>2</sup>

The fear of being stigmatized by peers is thought to be a major barrier when it comes to adolescents seeking needed mental health treatment. Chandra et al. (2007), showed that the anticipated negative stigma towards mental illness from family, peers, and school staff were key factors in an adolescent's comfort and willingness to seek treatment.<sup>22</sup> In a survey of high school students, approximately one out of every eight students reported that they would not pursue treatment for mental health issues, even if they believed it would be helpful, due to the fear of being stigmatized by their peers.<sup>23</sup> There is evidence that supports this fear. In a study conducted by Hartman et al (2013), a group of 3,000 high school students was surveyed and only one third of them knew what schizophrenia was. Of the students who reported being familiar with schizophrenia, 17.7 percent of them reported that people with schizophrenia were likely to be violent.<sup>23</sup> Martin et al. (2009), showed that many Americans reported reluctance regarding interacting with or allowing their child to interact with, other children who have a mental illness.<sup>24</sup> This kind of stigma can also lead to discrimination in work and school environments.

Adolescents stigmatize and react with prejudice to their peers who are diagnosed with a mental

illness.<sup>25</sup> This stigma and prejudice can escalate to behaviors known to be risk factors for increased mental illness in adolescents, such as bullying.<sup>26</sup>

Hispanic adolescents are vulnerable to stigma because of their age and ethnicity. Hispanic adolescents fear facing prejudice and possible bullying by their peers. Not seeking care for their mental illness can put them at risk for developing unhealthy behaviors. They are at higher risk of not completing high school. The program that will be developed will aim to reduce mental health stigma. This will create an environment where it is acceptable with individuals with mental illness to seek treatment without fear of being discriminated.

### **Mental Health outcomes for Hispanic adolescents**

In 2016, there were 17.9 million Hispanics younger than 18 years old and 14.6 million between the ages of 18 and 33.<sup>27</sup> Hispanic youths have a high prevalence of depression and anxiety compared to non-Hispanic Whites.<sup>28</sup> In a Youth Risk Surveillance report for 2015 conducted by the Centers of Disease Control and Prevention (2016), both Hispanic adolescent male and female youth experienced higher rates of thoughts of suicide and likely attempts of suicide compared to non-Hispanic Whites.<sup>29</sup> Approximately 7.6 percent of Hispanic males had attempted suicide compared to 3.7 percent of non-Hispanic White males.<sup>29</sup> In females, 25.6 percent of Hispanics had seriously considered suicide compared to 22.8 percent of non-Hispanic White.<sup>29</sup> Feeling sad or hopeless was also higher among Hispanic females than non-Hispanic Whites. The Hispanic females had the highest rates at 46.7 percent compared to non-Hispanic Whites at 37.9 percent in this category.<sup>29</sup> A summary of these results can be seen in Table 1. Risk factors that likely exacerbate this issue include challenges such as lack of economic resources,

behavioral issues, and low educational attainment.<sup>28</sup> Another issue that likely negatively impacts mental health is the stress of immigrating to the United States and dealing with acculturation.<sup>28</sup>

Table 1 Youth Risk Surveillance Summary<sup>29</sup>

Youth Risk Surveillance Report Summary				
Behavior	Percent experienced			
	Hispanic females	Hispanic Males	Non-Hispanic White female	Non-Hispanic White Male
Seriously Considered Attempting Suicide	25.6	12.4	22.8	11.5
Made a Suicide Plan	20.7	10.9	18.4	9.3
Attempted Suicide	15.1	7.6	9.8	3.7
Felt Sad or Hopeless	46.7	24.3	37.9	19.2

In addition, Hispanic adolescents are more likely than non-Hispanic whites to have less than optimal health care status.<sup>30</sup> Hispanic migrant children are also less likely to receive preventive care and receive lower quality care at hospitals.<sup>30</sup> Hispanics are also less likely to be hospitalized for mental illness than Whites or Blacks.<sup>30</sup> They are also less likely to seek mental health care services, or receive clinical or school-based interventions, and are less likely to receive pharmaceuticals to treat mental illness than non-Hispanic whites.<sup>31</sup> NAMI states that of all the Latinos with a psychological disorder, only 20 percent sought treatment from a physician and only 10 percent received contact from a specialist.<sup>32</sup>

Finally, the stigma associated with mental illness has been shown to be contingent on aspects that allows certain individuals to identify others as different such as social, economic, and political status.<sup>24</sup> Members of disadvantaged groups have been shown to be more likely to have negative labels associated with them and race as well as the ethnicity of a person with

mental illness impacts how people react to them.<sup>24</sup> The California Well-Being Survey reported Hispanics interviewed reported experiencing higher levels of self-stigma including feeling embarrassed, ashamed, and not being understood because of a mental health problem.<sup>33</sup> They were more likely to say that they would conceal a potential mental health problem from coworkers or classmates than whites. They were also the most likely to put off treatment for fear of letting others know about their mental health issues.<sup>33</sup> Compared to other ethnic or racial groups Hispanics are among the least likely to seek aid for a mental illness.<sup>33</sup> Many Hispanics report that they do not seek treatment because they do not want to be labeled as “locos” or “crazy”.<sup>32</sup> This label can be associated with losing control, being violent, and never being able to be cured.<sup>34</sup>

Hispanics have a high stigma towards mental illness. This then leads to decreased service utilization when it is needed. Hispanic adolescents, when compared to non-Hispanic whites, have higher levels of suicidal ideation. In order to decrease this and make it more equal, mental health stigma needs to be addressed. Hispanics should not be ashamed of seeking help for their mental illness. To address this, we must first look at interventions that have helped in reducing mental health stigma.

### **Interventions to Reduce Stigma in Adolescents**

There are three primary methods that have been shown to be effective at changing an individual's views on mental health and reducing the stigma associated with mental illness. They are: protest, education, contact used individually or in combination.<sup>35</sup> An example of protest is not allowing negative depictions of people with mental illness to be shown in the media or other mainstream sources. The implementation of a contact intervention usually involves someone

with negative beliefs towards something, such as mental illness, coming into contact with an individual who they attribute that belief to. In this case, a person with a mental health illness meets with someone that stigmatizes individuals with mental health illness. Educational interventions focus on addressing incorrect stereotypes about mental illness by replacing them with correct information.<sup>35</sup> Corrigan et al. (2012) report a meta-analysis that examined the effects of anti-stigma approaches. In this analysis 24.1 percent of the research participants were adolescents.<sup>35</sup> While the analysis did not give specifics on how many of these adolescents were Hispanic, it did state that 5.6 percent of the total participants were of Hispanic or Hispanic American ethnicity.<sup>35</sup> The analysis found that overall contact-based interventions were the most effective among adults at reducing mental health stigma among this group.<sup>35</sup>

In the Corrigan analysis, educational interventions had the largest effect on reducing mental health stigma among adolescents.<sup>35</sup> Contact-based interventions were also shown to reduce mental health stigma among this age group but not as much as an educational approach.<sup>35</sup> One possible explanation for the effectiveness of this kind of intervention is because it is believed that adolescents have not yet formed strong attitudes towards mental illness.<sup>35</sup> These interventions can also be effective long-term because individuals with more information and knowledge of mental health illnesses are less likely to discriminate or reinforce negative stereotypes.<sup>36</sup>

Giannakopoulos, Assimopoulos et al. (2012) targeted adolescents aged 16-18 by implementing a school-based intervention and providing three 90 minute educational workshops.<sup>37</sup> The workshops included clarifications about incorrect stereotypes such as perceiving those with mental illness as violent.<sup>37</sup> Other topics included information on therapeutic interventions and how those with a mental illness are able to work and make decisions for themselves.<sup>37</sup> The



group that received the intervention reported to be more willing than the control group to work with an individual with a mental illness, that they would tolerate having a neighbor with a mental illness, and that they would have casual conversations with those with mental illness.<sup>37</sup>

A study done in 2009 by Chan et al. studied the impact of an anti-stigma program on adolescents in Hong Kong that used three possible intervention approaches to reduce stigma. The researchers compared the effects of: (a) a 30-minute educational lecture; (b) a prerecorded video followed by an educational lecture, and (c) educational lecture followed by the prerecorded video on stigmatizing attitudes. The results of the study showed that those who participated in the education lecture followed by the prerecorded video group had a significantly lower stigmatizing attitudes compared to the other two groups.<sup>38</sup> At the 1-month follow-up, the effects were still evident, but they did notice that the effects lessened over time.<sup>38</sup>

Video games have also been used as a way to implement an educational intervention to reduce mental health stigma in the adolescent population. In Spain, Cangas, Navarro, et al. (2017) developed a program using a video game to diminish the negative stereotypes of individuals with mental health illness. This game featured main characters who were diagnosed with schizophrenia, bipolar disorder, depression, and agoraphobia and attempted to tackle the perceptions of people with these issues. The main objective of the game is to convince these main characters to work together towards a common goal. The player must choose the correct and most appropriate approach to interact with the characters. The participants' ages were between 14 and 18. The results of this intervention showed that individuals that participated in the video game were less likely to view those with mental health illness as dangerous compared to those that did not play the game.<sup>39</sup>

Bulanda, Bruhn, et al. (2014) described a peer to peer intervention named “Share, Peace, Equality, Awareness, and Knowledge” (SPEAK) in Illinois. This was a youth-led program designed to help at-risk students by targeting mental health stigma and promoting help-seeking behavior by training students to be peer health educators. 40 Enrolled students had a demographic makeup of 60 percent Latino, 22.7 percent African American, and 14.4 percent white. These youth leaders developed their own presentations addressing different mental health disorders including a video of a teenage girl being teased for seeking help for her mental health issues and then presented them during an after-school program for at-risk students in middle schools. The post-test results of this intervention demonstrated a positive impact on attitudes towards individuals with mental illness.

While there were no studies describing interventions that specifically targeted Hispanic adolescents or Hispanics in general, a study conducted in 2016 by Vinson, Abdullah, and Brown examined lowering mental health stigma in African Americans.<sup>41</sup> The aim of this study was to evaluate if contact-based interventions were effective among African Americans. According to Vinson et al, there had been no interventions that had specifically looked into this.<sup>41</sup> The mean age of participants was 19.36.<sup>41</sup> The intervention was presented in two forms: in-person presentation and a video presentation. For the in-person contact group, they heard an African American man discuss his experiences with panic disorder. The man was also recorded and that was used as the video presentation for the other group. While there was a decrease in stigma in both groups after the intervention, there was no significant difference between the decrease for the participants who watched the video and the individuals who attended the presentation.<sup>41</sup> This intervention is important because it focuses on a marginalized minority group similar to

Hispanics. It demonstrates that a contact based intervention that focuses on specific areas that affect a minority group could be successful in reducing mental health stigma.

The interventions described above used a mixture of education and contact. Interventions also examined the difference between video and in vivo contact. There was no real difference noted between the two but they both were effective in reducing mental health stigma. The order in which the intervention was given was also tested. Educational lecture followed by video was more successful than the reverse. A summary of the interventions can be seen below in table 2. Before the intervention is created, there are key considerations that need to be accounted.

Table 2 Summary of Interventions

<b>Author</b>	<b>Hispanics included in study?</b>	<b>“Exposure”</b>	<b>Results</b>
Corrigan et al. (2012)	Not specified	A meta-analysis on multiple outcome studies	For adults: Contact based interventions most effective. For adolescents: Educational interventions most effective but contact based also made an impact
Giannakopoulos, Assimopoulos et al. (2012)	No	Educational intervention with a control group; Three weekly 90 minute workshops	The intervention group experienced more positive changes in attitudes towards those with mental illness compared to the control group.
Chan et al. (2009)	No	Examined three different combinations utilizing education alone, education followed by video contact, and video contact followed by education	The education followed by the video had the greatest effect in reducing mental health stigma. Education alone performed better than the video followed by education.
Cangas Navarro, et al. (2017)	Spain	Video game	Participants that played the game were less likely to have negative attitudes about individuals with mental illness compared to those that did not participate
Bulanda, Bruhn et al. (2014)	Yes	Peer-based contact, video, and educational intervention	Participants had decreased negative attitudes about mental illness and individuals that are mentally ill
Vinson et al. (2016)	No	Examined if there was a difference in effectiveness between contact based or a prerecorded video	Both groups experienced a decrease in mental health stigma but there was no difference between the two groups

## **Key Considerations for Developing a Stigma Reduction Program for Hispanic Adolescents**

In the meta-analysis described above, Corrigan et al. state that interventions to reduce mental health stigma should be kept at the local or grassroots levels.<sup>35</sup> They describe stigma as being shaped by an individuals' experience and social contexts.<sup>35</sup> Therefore, we should encourage local communities with large concentrations of Hispanic adolescents to address mental health stigma in a way that more effectively meets their needs. It is also important that this intervention be more culturally competent and take into consideration Hispanic cultural norms as described below.

There are several key considerations in developing a stigma reduction intervention for Hispanic adolescents. An article from 2009 by Kramer et al., describes different cultural aspects that should be considered.<sup>34</sup> Language is clearly the most important. Someone who is bilingual best expresses or is more emotionally involved when they are discussing sensitive subjects in his or her native language.<sup>34</sup> However, individuals who have been highly acculturated respond better in English.<sup>34</sup> This can be an issue when developing a program for Hispanic adolescents since there might be a mixture of the two scenarios. However, Zayas and Pilat (2008) reported that adolescents are more likely to acculturate at a faster rate than their parents.<sup>42</sup> Based on this finding, the ideal intervention for Hispanic adolescents should be in English.

Religion is should be kept in mind when addressing stigma among Hispanic adolescents. A large percentage of Hispanics consider themselves Catholic.<sup>34</sup> Hispanics are likely to believe in spiritualism, or *Espiritismo*, attribute diseases with natural or supernatural forces and a belief that mental and physical illnesses can occur because of karma or not be following religion.<sup>34</sup> It is important to keep this in mind when developing an intervention in order to educate individuals on mental health. The audience receiving the intervention should feel that they are not to blame

for having a mental illness. Also, religious leaders could be considered important stakeholders in an intervention.

One other key consideration in developing an intervention aimed at Hispanic adolescents is the importance of family. In some Hispanic culture, with national variation taken into account, the family comes first and it is normal to relinquish personal gains for what is best for the family.<sup>42</sup> This can be a problem if someone is worried that their mental illness can bring stigma towards their family. Individuals with mental illness might also worry about being spurned by their family.<sup>34</sup> Hispanic communities prefer to remain very private.<sup>32</sup> It is common practice to live by the phrase “don’t air your dirty laundry in public” and that means seeking help or speaking to others about mental illness is negatively viewed. The family might see that person seeking aid as an embarrassment because they are sharing their personal information. Mental illness can also reflect negatively on the family and deteriorate social relationships.<sup>34</sup> Therefore, when creating an intervention is important to consider the familial aspect of Hispanic culture. To address two different areas need to be looked at. The first is dealing with a family member that has a mental illness and the importance of not ostracizing them from the family. The second is how members of the family who have a mental illness should speak to family members so that the family learns that those that are mentally ill are not violent and unstable. Finally, any intervention should touch on different options available within their community for receiving aid for those that feel might be experiencing a mental illness.

It is important that any intervention use language that is not too complicated and includes words and phrases that are used among Hispanic adolescents in that community. A study done in 2011 by Knifton L, described a failed anti-stigma campaign aimed at minorities in Scotland.<sup>43</sup> The campaign used media posters to convey their message to reduce stigma among these groups.

The results showed that the campaign had no impact on reducing stigma. It was later discovered that one of the reasons for this was because the language used in the intervention did not correspond to words used by the targeted ethnicities.

### **Implementing a stigma reduction intervention targeted at Hispanic adolescents**

The proposed intervention will take place at schools that have a significant number of students from Hispanic backgrounds. The intervention will be modeled after the SPEAK program (Bulanda et al. (2014)) described previously but will only focus on Hispanic adolescents. This approach was chosen because the original program had a large representation of Hispanic adolescents. The program will also be taking ideas from the one described in Vinson et al. 2016 which was targeted at the African-American community and utilized words and themes associated with mental illness from this community. The same will be done here with terms that are most common among Hispanics. The intervention will take place after school in order to reach a larger number of adolescents. After-school programs have also proven to be effective in other programs that have been implemented.<sup>44</sup> As a pilot program, the scope of the intervention described in this paper will be a single school

The intervention for the proposed program is described below using the template of intervention description and replication TiDier checklist.<sup>45</sup> The checklist describes the materials (the WHAT), the providers (the WHO), the location (the WHERE) and the mechanism or dosage or the intervention (HOW or HOW MUCH). The components of the checklist are shown below. A logic model for the program is shown Appendix I.

### **Program Description**

The program will be given to a group of students after school. It should be less than fifty students per group. The student groups will be also separated by grade in school. Students will be

able to sign up for a session with the school administrators. The program will be promoted by school teachers and staff. The program will specify that this is geared for Hispanic students specifically those with Mexican origin. About ninety-six percent of the high school is Hispanic.

<sup>46</sup> The program will start with a five-minute introduction followed by a 15 presentation by the group facilitator. After this, the video by Say-It-Out-Loud will be viewed. This video is approximately under 6 minutes. Following the video, there will be a thirty-minute questions and answers. The final five minutes will be closing thoughts or statements.

### **Program Setting**

The program will take place at Bell Senior High School in Los Angeles County. This school was chosen due to its high number of Hispanic adolescents. Over ninety-six percent of the school identifies as Hispanic. Out of the 2,953 students enrolled as of the 2016-2017 student school year, 2,609 received free or reduced lunch.<sup>46</sup> The school gymnasium or cafeteria can be used for an after-school program.

### **Program Timeline**

The program will be given as a single dose. The program's aim is for start in 2019- 2020 school year. The start of the school year, based on the Los Angeles Unified School District is August 20th. In order to allow enough time for promotion of the program, the initial start date of the program should be October 22nd. The program will be given after school. The first day will be for 12th graders. The second day will be for 11th. The third day for 10th graders. The last day will be for 9th graders. The program will also run for a second time the next week following the same order as before. This is to make sure that we have enough program participants. The program should last about 61 minutes. For more specific information please view the timeline in Appendix 1.



## **Program Staff**

In order to create the materials needed for this program and to follow all the procedures required, the following program staff will need to be hired.

*Program manager and coordinator:* A program manager will run the program. The SPEAK program was run by two social workers. The program manager will be involved in all aspects of the program, will help create the program materials and will also be responsible for connecting with stakeholders and disseminating information. Program coordinators may also be needed who may be community members who will speak to the school and community leaders.

*Group presenters:* The group presenters will be individuals that are Hispanic with a mental illness. Since the targeted school will be in Los Angeles County, the individual should identify as Mexican or Mexican American. The largest populations with Hispanic origins are Mexicans followed by Salvadorans.<sup>47</sup> The group presenters will be recruited from the university where the partnership was formed. The presenter should be willing and able to share and discuss their mental illness. They will be trained and educated on mental health stigma. They will learn some of this through the NAMI Say-It-Out-Loud toolkit. They will also learn how to facilitate a group.

*Health educator:* A health educator will be contracted to aid in developing and modifying educational material. They will be responsible for modifying this program to for Hispanic adolescents. They will also teach the group presenters about mental health illness. The health educator, with the program coordinator, will aid the group presenter in creating a short script to discuss their experience with mental illness. The health educator will also be present during the program to help address any difficult questions that the group presenter is unable to answer.

*Coach:* The program will also need to contract a coach. The coach will assist in hiring the right group facilitators. The coach's responsibilities will include training group facilitators with

Say-It-Out-Loud. The coach will also be responsible for keeping engagement with the school. They will also be responsible in explaining the program to the school administrators. They will aid in creating promotional flyers to attract students to the program. .

*Program evaluator:* A program evaluator will be contracted to be in charge of the monitoring and evaluation. They will work alongside the program coordinator in developing the pre-and posttest. They will train students in aiding them in collecting the data that is necessary to perform an evaluation. They will also be responsible for delivering results to the program coordinator. From there, the two of them will share the results with the stakeholders and program staff.

*Student assistants:* In the SPEAK program there was a partnership with a university in Illinois. Students there aided in the program. Therefore, a partnership with a local university will be sought. Students will be able to receive school credit based on their participation hours in the program. Students will help with administrative duties, implementing the program, and its evaluation. Each individual student will receive training based on the area they assisting.

## **Materials Required**

In order for the intervention to be effective, it will need informational materials. This material will consist of similar educational content utilized by the SPEAK program. Their program used the Say-it-Out-Loud tools provided by National Alliance on Mental Illness. The Say-It-Out-Loud toolkit includes a 5 to 6-minute video that can be used in a presentation to aid in diminishing mental health stigma. The video shows the warning signs of mental illness as well as stories from three different adolescents about mental illness. NAMI also provides a narrated presentation and guide for the group facilitators. This presentation provides more information

about mental illness as well as pointers on how to conduct a group discussion. Other contents in this toolkit include a fact sheet with information on other ways to get involved with NAMI.<sup>1</sup>

Additionally, a narrative will need to be created based on the stories that will be shared by the presenters. This lecture material will be created alongside the program coordinator and the health educator. The material will cover information on specific points that will be addressed during this presentation. It will include the individual's experience with a mental illness. Flyers will also be made to promote the program. These flyers will then be handed out to the school to give to teachers and/or post around the school. All of the lecture material will be created in English.

## **Procedures**

There are multiple procedures that need to occur in order for this program to run smoothly.

*Before the program is implemented:*

1. Hiring staff to meet the needs of the program.
2. Training of group presenters.
3. Creation of material that will be used for the program.
4. Creating an evaluation plan.
5. Reaching out and building a relationship with Bell Senior High School in Los Angeles.
6. Engaging with stakeholders.
7. Promotion of the program will take place in the school. The program will start promoting the event 6 weeks before the initial start.

---

<sup>1</sup> For further information on this content please visit NAMI's Say-It-Out-Loud website at <https://www.nami.org/Extranet/Education,-Training-and-Outreach-Programs/Outreach-and-Advocacy/Say-It-Out-Loud>

*During the program's implementation:*

1. The students will be given a pretest to determine their attitudes toward mental health illness and treatment.
2. The presenter will explain the purpose of the program and the ground rules based on NAMI's Say-It-Out-Loud suggestions.
3. The presenter will discuss their story with mental illness.
4. The video will then be viewed, followed by a question and answer session.
5. Posttest will be given to measure if students attitudes have changed.

*After the program is implemented*

1. The results will be interpreted.
2. Posttest will be readministered after two months.
3. Information will be shared with stakeholders.

While the program described above gives more specifics on what will need to be done, who will do it, and how, it is important to consider how the program will be modified to meet the needs of Hispanic adolescents. The program will not be molded to treat all of these Hispanic subgroups as the same. These are some of the subgroups: Mexican Americans, Puerto Ricans, Cubans, recent immigrants, or first-generation adolescents. All of these groups may experience different types of environmental and social factors that can contribute to their mental health stigma.<sup>28</sup> It is important that the population the intervention is being molded for view the individual chosen to present the information as an equal and someone from their own community.<sup>36</sup> These environmental and social factors might also contribute to their participation in the program.

### **A Model for Program Implementation: The Interactive Systems Framework**

The Interactive Systems Framework for Dissemination and Implementation can be used to guide the program implementation. This framework was originally created to help translate research into the field.<sup>48</sup> The three systems of ISF that can be used to adapt an intervention to meet the needs of Hispanic adolescents in that particular community are the Synthesis and Translation System, the Support System, and the Delivery System.<sup>48</sup> The synthesis and Translation System reviews the research for the most effective interventions and adapts it for Hispanic adolescents. For example, when the group facilitator discusses topics such as family, misperceptions about mental illness or resources available in the community, they will use words that are common among the Hispanic community in describing an individual with mental illness. Those words have been described by Krammer et al. (2009) to include *locos*, *nervios*, and *sustos*.<sup>34</sup> Loco is a word used to describe someone they believe is crazy. Once someone has been labeled loco it is difficult for that person to remove that label in the community.<sup>34</sup> Nervios is a description that is more used to for someone with anxiety. Finally, sustos is used to describe someone that experiences a traumatic event and starts to experience symptoms of depression.<sup>34</sup>

The next system in the ISF is the Prevention Support System. This is how the work will be supported.<sup>48</sup> This includes program faculty, activities, resources, and materials.

The third system of the ISF is the Delivery System. This is where the program is implemented in the school. In this case, the school chosen was a high school. The SPEAK program was conducted in a middle school. The majority of students are considered low income in both the SPEAK program and the school selected for this intervention. Recruitment of

students to participate in the program is different. In the SPEAK program, students were picked based on their at-risk status. This program will be open to anyone to attend.

Other areas of ISF are needed for the program to be successfully implemented including existing research, funding, climate and macro policy. Identifying possible grants or partners should be a priority before proceeding. The climate of the community should also be evaluated before forming a relationship. It is critical to make sure that the community is receptive to supporting a program aimed at tackling mental health stigma in Hispanic adolescents. Lastly, it is also important to understand if there are any policies that impact mental health in Hispanic adolescents in the community, county, or state.

Stakeholders will need to be identified before the start of the program. This will be done by the program manager with aid from the health coach. Some of the stakeholders will include the Los Angeles County Department of Public Health, community leaders, and the Los Angeles Unified school system board. Public health officials will aid the program in identifying communities that could potentially be a good fit for the program. They can also help identify resources available in those communities. Community leaders can help in describing their community's unique attributes. This can be useful in identifying ways to best present the information using language that can resonate with Hispanic adolescents in that area. As we want this program to remain a grassroots intervention, it is important that the community feels invested in this intervention. The school board can provide further information about the student's demographics. They can also help in getting the different schools' Parent Teacher Associations (PTA) involved to promote the program. Other possible support may be obtained from other programs in the area also working with adolescents or in addressing mental health in

the community. Therefore, it is essential to form a network with these other programs to gain more information on what has aided them in reaching this population or addressing this problem.

There might be several implementation challenges expected. Due to this being an after-school program, getting Hispanic adolescents to attend might be a challenge. It is imperative that the school promote the after-school program. Keeping the school administrators and faculty motivated could also be a challenge. It is important that the relationships formed are long-lasting and that the school feels that they are part of implementing the program as well. The relationship with the school will be built by the program manager and coach. If the program proves to be a success, the community or communities themselves can take ownership of this intervention. Sustainability could also be an issue if proper funds are not obtained.

The primary goal of this intervention is to reduce mental health stigma. With the aid of all the toolkits described, the SPEAK program can be adapted to meet the needs of Hispanic adolescents. The program will run in a high school and it will be open to all Hispanic adolescents. While the SPEAK program used high school peer educators this intervention will use facilitators from the local university that are Hispanic and have a mental illness. ISF will aid the program being adapted to address specific problems that affect stigma in Hispanics.

## **Evaluation Plan**

An evaluation plan is needed to determine how the program is performing. This will include a process and outcome evaluation. The evaluation will include a qualitative and quantitative component. The quantitative component will be primarily a pretest and posttest given during the sixty-minute program. The outcome evaluation will be modeled after questions asked during the SPEAK program. The qualitative component will consist of interviews with students to assess their experience and satisfaction with the program. The information will be

gathered by the student volunteers and the evaluators. This includes but not limited to health educators, volunteers, evaluator, and the program manager.

Process evaluation is crucial because we need to determine if the program execution is working. This part of the evaluation will also include the number of participants that were in each session. The sign up and sign in sheet will be used to determine the number of individuals that did not show up. This will help us determine if participants did not participate because there was a lack of sign ups or because something happened between signing up and the program date.

Since the program will consist of multiple parts it is important to find out if there is one part that is not working or one that is working better than the other. The three parts of the program are the group facilitator's narrative, the Say-It-Out-Loud video, and the questions and answers. A qualitative approach will be helpful in this situation. The interviews will be conducted after the program has taken place. The interviews will be conducted by the evaluator and student volunteers. The number of interviews after each session be based on the number participants that attend the program. Ideally, we will interview 10% of participants in each session. The interviewees will be chosen at random.

To assess the sustainability of the intervention, participants' contact information will be gathered during the sign-up process. This will be done by the school administrators. This information will be used to contact them 2 months after the program's implementation. They will be given the same posttest after the intervention. This is to determine if the attitudes have changed over a period of time.

The results of the evaluations will be shared with stakeholders and program faculty to improve program implementation. The process evaluation results will be reviewed as they arrive.



It is important that this is done this way in order to adjust the program dynamically. For instance, if the program session is opened for 50 students but only half are showing up; then we can reopen the sessions for more students in order to adjust for the students that do not come.

Table 3 Monitoring and Evaluation Plan

<b>Monitoring and Evaluation Plan</b>			
Process Goals	Evaluation Question	Participant	Evaluation Method
40 Participants in each of the 8 sessions	How many participants attended each question?	Evaluator, Volunteers	Sign-up sheet, sign in sheet, number of pre- and posttests
Participants find the contact based narrative helpful	Did you enjoy listening to the narrative?	Evaluator, Volunteers	Qualitative and Quantitative: Posttest, comments can be further evaluated with interviews
Participants find the video helpful	Did you enjoy watching the video?	Evaluator, Volunteers	Qualitative and Quantitative: Posttest, comments can be further evaluated with interviews
Participants find the questions and answers helpful	Did you enjoy the questions and answer forum?	Evaluator, Volunteers	Qualitative and Quantitative: Posttest, comments can be further evaluated with interviews
Outcome/ Sustainability Goals			

Participants are not afraid of talking to someone with a mental health illness	Are you afraid to talk to someone with a mental illness?	Evaluator	Pre-and Posttest
Participants are not upset about having a classmate with a mental illness	Would you be upset with having a classmate that has a mental illness?	Evaluator	Pre-and Posttest
Participants do not believe individuals with mental illness are dangerous	Do you think those that are mentally ill are dangerous?	Evaluator	Pre-and Posttest
Participants can recover from a mental illness	Do you think individuals that seek treatment can recover from a mental illness?	Evaluator	Pre-and Posttest

## **Roles of Leaders in Reducing Mental Health Stigma among Hispanic Adolescents**

### **Public Health Leaders**

Public health leaders have a responsibility to address inequities. Lack of utilization of mental health care services in Hispanics needs to be addressed. One way to do this is to address mental health stigma. Public health leaders should also urge officials to allocate more resources and money to address mental health. Besides seeking funding, it is important that public health leaders continue to focus on research to find effective ways in reducing mental health stigma in order to increase help-seeking behavior. There should be a special focus on minority groups where research has not been fully done. It is also up to public health leaders to make sure that interventions that have been proven to be effective are the ones that are being implemented appropriately. Lastly, it is important that public health leaders keep this issue as a constant priority and not only when an event occurs that brings a spotlight to mental illness.

### **Community, State, and National Leaders**

It is vital that not only public health leaders but leaders in other areas address mental health in Hispanic adolescents. Leaders in school systems should advocate for the wellbeing of their students. As mentioned earlier, mental health issues can play a role in students missing class or dropping out. Local government officials should advocate for more funding to address mental health in their communities. Government officials at the state and national level should allocate more funds to address this issue. They should create a policy that creates an environment for Hispanic adolescents to seek mental help treatment as well without financial worry.

## **Conclusion**

The short-term and long-term impact that stems from mental illness within the adolescent population is one that if left untreated has severe consequences. This is especially true for the Hispanic adolescent population, which has been shown to have high levels of depression, thoughts of suicide, and suicide rates. 29 As stated above, one way to address this issue is to reduce the stigma associated with mental illness. Due to Hispanic adolescents being less likely to seek help for their mental illness compared to their non-Hispanic White counterparts for fear of being considered “loco” this is one area that can be targeted.

I have discussed intervention approaches that have been shown to be effective at targeting stigma within the general population as well as adolescents. Both educational and contact-based interventions have been proven to be the most effective at reducing mental health stigma and have also been shown to be effective when used in conjunction with one another.

Additionally, while peer to peer programs have been implemented and showed positive results, further long-term studies need to be done within the adolescent population to determine if these have any detrimental impact on the participating peer who has a mental illness. It is also important that these interventions address stigma within this population remain at the community and grassroots level. This ensures that the program can be specifically tailored for that population and more adequately address their particular needs.

The recommended intervention mentioned described in this paper aims at targeting Hispanic adolescents and lowering their mental health stigma. With the aid of community leaders, public health, and school officials decreasing mental health stigma can increase mental health service utilization among this population group. This after school-program conducted by a Hispanic individual can help diminish negative stereotypes attached to mental illness. This

intervention can also help provide further information for other possible interventions aimed primarily at minority population groups.

While these recommendations can help address the serious issue of mental illness and stigma within the Hispanic adolescent population, there are numerous factors that also play a role and impact this issue. One area that would increase the success of these interventions is the additional services available for Hispanic adolescents to meet their mental health needs.

Currently, there is very limited data on mental health stigma in general, and even less on mental stigma in minority populations. In order to truly address this issue, more research needs to be done on mental health stigma within the Hispanic adolescent population as well as other minority populations. Instead of generalizing data from other groups onto these populations, more targeted research would aid future programs in creating interventions that better address the needs of these populations.

## Appendix 1

Logic Model

Inputs	Actions	Outputs	Short Term Outcomes	Middle term Outcomes	Long Term Outcomes
Grants/Money	Train group facilitators	Group Facilitators will keep participants engaged	Stigma attitudes decrease	Increased help seeking behavior	Decreased suicide ideation in Hispanic adolescents
Staff	Develop a first-hand narrative of dealing with mental illness		Awareness of warning signs		Improved Perception of Individuals with a Mental Health Illness
Volunteers	Promote program in school	Program will be given to 50 participants at a time	Knowledge about Mental Health Illness	Individuals with mental illness experience less stigma	Decreased school truancy
Evidence Based Research	Tailor program to meet the needs of Hispanic Adolescents				
Educational Information	Program given after school	Evaluation report given to Stakeholders			Decreased unhealthy behavior
NAMI Say-It-Out-Loud Toolkit	Program will run for two weeks				
Partnerships	Hour long presentation with group facilitator				
Materials for promotion	Evaluation of program				

Timeline:		
Action	Performed by	When
Secure funding	Program Managers	Before the start of the program
Partnership with local University	Program Managers	0- 3 months from program start
Hire staff - health educator, coach, evaluator	Program Managers	0-3 months from program start
Recruit student volunteers from the university	Program Managers	0-3 months from program start
Train volunteers in duties	Program Managers	0-3 months from program start
Build relationship with Bell Senior High School	Program Manager	0- 3 months from program start
Identify Stakeholders	Program Managers	0-3 months from program start
Build relationship with stakeholders	Coaches, Program Managers	after the first three months of the program. This will be continuous
Continue to build relationship with school	Coaches, Program Managers	continuous
Search for group facilitators at the University	Coaches, Program Managers	months 3 - 6
Material will be created and modified	Health Educators	months 3 - 6
Train group facilitators with assistance of NAMI's Say-It-Out-Loud toolkit	Health Coach	months 6-8
Develop pre-and post-test	Evaluator, Program Manager	months 6- 8

Aid group facilitator in preparing narrative	Health Educators	months 6- 8
Develop promotional material	Volunteers, Health Coach	months 8-10
Begin pilot testing	Program Managers, Group Facilitators, Volunteers	months 8-10
Develop evaluation plan	Evaluator, Program Manager	after month 8th
Begin promotion of program	Volunteers, Program Managers	month 10
Evaluate pilot testing results	Program managers, evaluators	month 11
Facilitate program	group facilitators, program managers, volunteers	month 12
Evaluate program results	Evaluator, Program Manager	month 13
Disseminate results and information	Program Manager	month 14



## **Resources**

1. Corrigan P. How stigma interferes with mental health care. *Am Psychol*. 2004;59(7):614-625.
2. NAMI. Mental Health by The numbers. N.D; <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>. Accessed 04/2018, 2018.
3. McLaughlin KA, Costello EJ, Leblanc W, Sampson NA, Kessler RC. Socioeconomic status and adolescent mental disorders. *Am J Public Health*. 2012;102(9):1742-1750.
4. Guidry-Grimes L VE. Mental Illness and Compounded Vulnerability: Overview. 2015; <https://guides.library.georgetown.edu/mentalillness>. Accessed 04/2018.
5. Homeless NCft. *Mental Illness and Homelessness*. National Coalition for the Homeless2009.
6. Kennedy-Hendricks A, Huskamp HA, Rutkow L, Barry CL. Improving Access To Care And Reducing Involvement In The Criminal Justice System For People With Mental Illness. *Health Aff (Millwood)*. 2016;35(6):1076-1083.
7. Serious Mental Illness Prevalence in Jails and Prisons. 2016; <http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695>. Accessed 04/2018, 2018.
8. McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Aff (Millwood)*. 2008;27(2):393-403.
9. Scanlon M. A New Look at Racial/Ethnic Differences in Mental Health Service Use Among Adults. 2015; <https://www.nimh.nih.gov/news/science-news/2015/a-new-look-at-racial-ethnic-differences-in-mental-health-service-use-among-adults.shtml>. Accessed 04/2018, 2018.
10. Hudson DL, Kaphingst KA, Croston MA, Blanchard MS, Goodman MS. Estimates of Mental Health Problems in a Vulnerable Population within a Primary Care Setting. *J Health Care Poor Underserved*. 2016;27(1):308-326.

11. Health BUSoP. *Equity: Health Disparities, Social Determinants & Vulnerable Populations*. Boston University;2016.
12. AHRQ. 2016 National Healthcare Quality and Disparities Report. In: Services USDoHaH, ed: Agency for Healthcare Research and Quality; 2017.
13. Dingfelder S. *Mental health care: Vulnerable populations still left behind*. American Psychological Association2009.
14. OpenStaxCollege. Stages of Development. N.D;  
<https://courses.lumenlearning.com/ws-u-sandbox/chapter/stages-of-development/>. Accessed 03/2018.
15. PsychologyToday. Adolescence. N.D;  
<https://www.psychologytoday.com/basics/adolescence>.
16. OfficeofAdolescentHealth. The Changing Face of America's Adolescents. 2016;  
<https://www.hhs.gov/ash/oah/facts-and-stats/changing-face-of-americas-adolescents/index.html>. Accessed 03/2018.
17. Adolescent Development. 2014; <https://my.clevelandclinic.org/health/articles/7060-adolescent-development>. Accessed 03/2018, 2018.
18. WHO. Maternal, newborn, child and adolescent health; Adolescent development. N.D;  
[http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/development/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/). Accessed 03/2018.
19. WHO. Child and adolescent mental Health. N.D.;  
[http://www.who.int/mental\\_health/maternal-child/child\\_adolescent/en/](http://www.who.int/mental_health/maternal-child/child_adolescent/en/). Accessed 04/2018, 2018.
20. NIMH. Mental Illness. 2017; <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. Accessed 03/2018.
21. WHO. Adolescents and mental health. N.D;  
[http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/mental\\_health/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/mental_health/en/). Accessed 03/2018.

22. Chandra A, Minkovitz, C.S. Factors that Influence Mental Health Stigma Among 8th Grade Adolescents. *Journal of Youth and Adolescence*. 2006;36(6):763-774.
23. Hartman L, Michel, N., Winter, A., Young, R. & et al. Self-Stigma of Mental Illness in High School Youth. *Canadian Journal of School Psychology*. 2013;28(1):28-42.
24. Martin JK, Pescosolido BA, Olafsdottir S, McLeod JD. The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *J Health Soc Behav*. 2007;48(1):50-67.
25. O'Driscoll C, Heary C, Hennessy E, McKeague L. Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence. *J Child Psychol Psychiatry*. 2012;53(10):1054-1062.
26. Scott JG, Moore SE, Sly PD, Norman RE. Bullying in children and adolescents: a modifiable risk factor for mental illness. *Aust N Z J Psychiatry*. 2014;48(3):209-212.
27. Patten E. The Nation's Latino Population Is Defined by Its Youth. *Hispanic Trends* 2016; <http://www.pewhispanic.org/2016/04/20/the-nations-latino-population-is-defined-by-its-youth/>. Accessed 03/2018, 2018.
28. Potochnick SR, Perreira KM. Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *J Nerv Ment Dis*. 2010;198(7):470-477.
29. Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance - United States, 2015. *MMWR Surveill Summ*. 2016;65(6):1-174.
30. Flores G, Fuentes-Afflick E, Barbot O, et al. The health of Latino children: urgent priorities, unanswered questions, and a research agenda. *JAMA*. 2002;288(1):82-90.
31. Garland AF, Lau AS, Yeh M, McCabe KM, Hough RL, Landsverk JA. Racial and ethnic differences in utilization of mental health services among high-risk youths. *Am J Psychiatry*. 2005;162(7):1336-1343.
32. Latino Mental Health. 2018. Accessed 03/2018.

33. Wong EC, Collins RL, Cerully J, Seelam R, Roth B. Racial and Ethnic Differences in Mental Illness Stigma and Discrimination Among Californians Experiencing Mental Health Challenges. *Rand Health Q.* 2017;6(2):6.
34. Kramer E, Guarnaccia, P., Resendez, C., Lu, F.G, & et al. *No Soy Loco!// I'm Not Crazy Understanding The Stigma of Mental Illness in Latinos.* 2009.
35. Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rusch N. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatr Serv.* 2012;63(10):963-973.
36. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. *Am Psychol.* 1999;54(9):765-776.
37. Giannakopoulos G, Assimopoulos H, Petanidou D, Tzavara C, Kolaitis G, Tsiantis J. Effectiveness of a school-based intervention for enhancing adolescents' positive attitudes towards people with mental illness. *Ment Illn.* 2012;4(2):e16.
38. Jenny Y.N Chan WWSM, Lawrence S.C. Law. Combining education and video-based contact to reduce stigma of mental illness: 'The Same or Not the Same' anti-stigma program for secondary schools in Hong Kong. *Social Science & Medicine.* 2009;68(8):1521-1526.
39. Cangas AJ, Navarro N, Parra JMA, et al. Stigma-Stop: A Serious Game against the Stigma toward Mental Health in Educational Settings. *Front Psychol.* 2017;8:1385.
40. Bulanda JJ, Bruhn C, Byro-Johnson T, Zentmyer M. Addressing mental health stigma among young adolescents: evaluation of a youth-led approach. *Health Soc Work.* 2014;39(2):73-80.
41. Vinson ES, Abdullah T, Brown TL. Mental Illness Stigma Intervention in African Americans: Examining Two Delivery Methods. *J Nerv Ment Dis.* 2016;204(5):400-403.
42. Zayas LH, Pilat AM. Suicidal behavior inLatinas: explanatory cultural factors and implications for intervention. *Suicide Life Threat Behav.* 2008;38(3):334-342.
43. Knifton L. Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review.* 2012;21(3):287-298.

44. Halgunseth LC, Carmack C, Childs SS, Caldwell L, Craig A, Smith EP. Using the Interactive Systems Framework in Understanding the Relation Between General Program Capacity and Implementation in Afterschool Settings. *American Journal of Community Psychology*. 2012;50(3):311-320.
45. Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ : British Medical Journal*. 2014;348.
46. Education CDo. *Bell Senior High School Report: 2016-2017 Enrollment by Ethnicity*. California Department of Education.
47. Motel SaP, E. The 10 Largest Hispanic Origin Groups: Characteristics, Ranking, Top Counties. 2012; <http://www.pewhispanic.org/2012/06/27/the-10-largest-hispanic-origin-groups-characteristics-rankings-top-counties/>.
48. Wandersman A, Duffy J, Flaspohler P, et al. Bridging the gap between prevention research and practice: the interactive systems framework for dissemination and implementation. *Am J Community Psychol*. 2008;41(3-4):171-181.